Overview

The ancillary pilot project will:

1. determine for each participating facility a per diem Medicaid ancillary cost per day based on state fiscal year (SFY) 1996 ancillary claims payments, inflated for the pilot period during SFY 1999. Throughout the remainder of this bulletin this amount will be referred to as the facility specific rate (FSR);
2. utilize a statewide standard payment per day for ancillary goods and services. The statewide standard payment per day (SSPD) equals $5.85;
3. pay a participating facility based on a risk/return model (Risk/return sharing between the facility and the Division will be in the form of a retrospective settlement considering the prospective ancillary allowance and the actual amount expended by the Division in payments to ancillary vendors.);
4. exclude from retrospective settlement calculation any patient with ancillary spending per patient day in excess of 500% of the statewide-average ancillary-per-diem payment for the period of the pilot project;
5. reconcile each facility's final payments at the end of the pilot project;
6. allow ancillary vendors to continue to bill the Division directly; and
7. make available for each participating facility monthly updates on ancillary spending.

Payment

A facility chosen to participate in the pilot project will be assigned to one of two payment groups depending on their FSR. (Please refer to Attachment A to determine the payment model for your facility) The groups are as follows:

1. Group I, Standard Payment Model: A facility will be assigned to this group if their FSR falls between the statewide standard of $5.85 and $7.02 (120% of $5.85).
2. Group II, Outlier Payment Model: A facility will be assigned to this group if their FSR falls either between $1.17 (20% of $5.85) and $5.85 or between $7.02 (120% of $5.85) and $11.70 (200% of $ 5.85). Facilities with spending levels less than $1.17 or greater than $11.70 are excluded from participation in the pilot project.

Billing

For administrative simplicity, vendors of ancillary goods and services will continue to submit claims to the Division directly, and the Division will continue to process these claims for payment.

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Final Settlement, Group I

There is no financial risk for facilities participating in this group. The baseline amount for this group is the statewide standard per diem of $5.85. Settlements at the end of the pilot period will be based on: payments to vendors during the pilot; the statewide standard per diem ($5.85); and the facility specific rate (FSR). The methods for settlement will be:

1. if vendor payments are less than the FSR but are greater than $5.85 (SSPD), the Division will pay the facility 25% of the difference between their FSR and actual vendor payments; or
2. if vendor payments are less than $5.85 (SSPD), the Division will pay:
   a. the amount calculated in (1) above, plus 50% of the difference between $5.85 and the actual vendor payments up to $2.93 (50% of $5.85); or
   b. if vendor payments exceed the FSR there will be no settlement with the facility.

Final Settlement, Group II

The baseline amount for this group is the amount equal to the facility specific rate (FSR). Final settlement will be based on the difference between vendor payments and the baseline amount (FSR). The methods for settlements will be:

1. if vendor payments are less than the FSR, down to and including 50% of that amount, the Division will pay the facility an amount equal to 50% of the difference; or
2. if vendor payments exceed the FSR, up to and including 150% of that amount, then the facility will reimburse the Division for 25% of the difference between that amount and the actual vendor payments.

Reconciliation and settlement through this approach effectively cap both the downside and upside financial exposure for facilities. Risk is capped at 12.5% of the FSR. Return is capped at 25% of the FSR.

Special Conditions

For ancillaries that are provided by the facility itself there will be no payment to the facility or to special vendors. These are services the facility decides to make rather than buy or to make special contracts with vendors for fees below levels in the MassHealth rate schedule. These amounts will not be considered part of the incurred vendor payments. This means that the facility and the Division will share in the reduction of vendor payments that may result from such arrangements. For these situations the facility will:

1. notify the Division (Lisa McDowell) in writing of the changes being made and the affected services; and
2. segregate the costs incurred in providing the goods and services.

Settlement examples and grids for both groups can be found in Attachments B and B1.

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Timing and Duration

The pilot project will run from October 1, 1998, through June 30, 1999. The project sample will constitute those residents in the facility on October 1, 1998, and those admitted to the facility between October 1, 1998, and March 31, 1999. The data collection period will run from October 1, 1998, through June 30, 1999, allowing all residents to be tracked for the duration of their stay or for three months, whichever is shorter. The final evaluation activity will occur from July 1, 1999, to September 30, 1999.

Evaluation Protocols

The evaluation will rely on facility pre- and post-pilot comparisons and comparisons with all nonparticipating facilities. The intent is to describe outcomes and issues of the administrative feasibility of bundled payment. The issues that will be examined include changes and/or differences in:

1. MassHealth payments for ancillaries, and for all health care taken together for patients served under the participating groups;
2. prescribing patterns and frequency of key, necessary therapies and pharmaceuticals, and the appropriateness of this care (including treatment for secondary conditions);
3. frequency and patterns of admission for persons with high ancillary costs or heavy care needs; and
4. corroborating evidence of changes in clinical and administrative decision making.

Evaluation Data Needs

Several types of data will be needed to answer the evaluation questions. These data include the following.

1. Medical records data.
2. MDS/MMQ data.
3. Claims and payment data for study patients. (Claims data in the baseline and post period will be provided by the Division.)
4. Qualitative management information — intensive case studies at 10-12 facilities. (These administrative studies will require two or three site visits each in order to document the changes in clinical and administrative decision making regarding ancillaries and the nature of in-house controls and physician interactions. It is also likely that the qualitative data collection will include focus groups or direct interviewing of persons conducting discharge planning in selected hospitals to determine if there are patterns of restricted access (difficult placement) for certain types patients in pilot facilities.)
5. Tracer conditions – selected conditions where pilot effects are expected to be most pronounced or most interesting.

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Selection Criteria

The selection of facilities to participate in the pilot project will be determined by the Division. At a minimum, facilities must meet the following criteria in order to be considered for participation in the pilot project.

1. Capacity of 60 or greater beds.
2. Facility-specific ancillary costs per patient day between $1.17 and $11.70 (See Attachment C).
3. No significant changes in facility operations since 1996 including, but not limited to: mission, licensure, and casemix.
4. No substandard quality of care issues identified by the Department of Public Health that may impact participation and/or outcomes of the study.

Obligations of Participants

Facilities that are selected to participate will agree to:

1. remain in the pilot for the duration of the project;
2. provide all necessary data including MDS on patients;
3. provide access for medical-record reviews;
4. allow interviews and observation by evaluators;
5. notify the Division of special arrangements for ancillaries; and
6. retain associated cost information.

Applications

Facilities that meet the minimum participation requirements and that are interested in applying should complete the Application Form found in Attachment D. The deadline for the receipt of applications is August 31, 1998. Send your applications to:

Lisa McDowell
Division of Medical Assistance
600 Washington St.
Boston, MA 02111

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ATTACHMENT B.

SETTLEMENT EXAMPLES

Group I. Standard Rate Model. State Standard Per Diem(SSPD) $ 5.85	***Facility and Risk/Share Information***
Historical ancillaries for this facility:	**$6.00 PPD** (Per Patient Day)
Rate allowed for this facility	**$5.85** (within the group of NF's paid the SSPD)
Limit on payments for profit sharing	**$2.93** (50% of the standard rate)
Retrospective Settlement:	
If payments to vendors are **$2.50** then state pays facility	50% * $2.93 = **$1.47**plus 25% *($6.00-$5.85=$0.15)= **$.038** Total Settlement: **$1. 50 PPD**
If payments to vendors are **$4.50** then state pays facility	50% *($ 5.85-$4.50 = $1.35) = **$.68** plus 25%* ($6.00-$5.85 = $0.15) = **$.038** Total Settlement: **$.71 PPD**
If payments to vendors are **$5.50** then state pays facility	50% * ($5.85-$5.50=$0.35 = **$.175** plus 25% * ($6.00-$5.85=$0.15) = **$.038** Total Settlement: **$.21 PPD** .
If payments to vendors are **$5.75** then state pays the facility	25%*($ 6.00-$5.75=$0.25) = **$.063** Total Settlement: **$.063 PPD**
If payments to vendors are **$6.95**	**No Settlement**

Group II. Outlier Rate Model. State Standard Per Diem(SSPD) $ 5.85	***Facility and Risk/Share Information***
Historical ancillaries for this facility:	**$5.00 PPD**(Per Patient Day)
Rate allowed for this facility	**$5.00** (facility specific rate)
Limit on payments for profit sharing	**$2.50** (50% of the facility specific rate)
Limit on payments for loss sharing	**$7.50**
Retrospective Settlement:	
If payments to vendors are **$2.50** then state pays facility	50% * ($2.50)= **$ 1.25(the limit)** Total Settlement: **$ 1.25**
If payments to vendors are **$4.50** then state pays facility	50% * ($ 5.00-$4.50 = $.50) = **$.25 PPD** Total Settlement: **$.25 PPD**
If payments to vendors are **$5.75** then facility pays the state	25% * ($5.75-$5.00=$.75) = **$.19** Total Settlement: **$.19 PPD**
If payments to vendors are **$ 8.50** then facility pays the state	25% * ($2.50)= $ **.63 (the limit)** Total Settlement: $ **.63 (the limit) PPD**

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ATTACHMENT B1

STANDARD PAYMENT MODEL

	$2.93 (50% SSPD)	$5.85 (SSPD)	FSR BASELINE	$7.02
			0%	0% NF RISK
			100%	100% DMA
NF: 0%	50%	25%		
RETURN				
DMA: 100%	50%	75%		

SETTLEMENT SHARES

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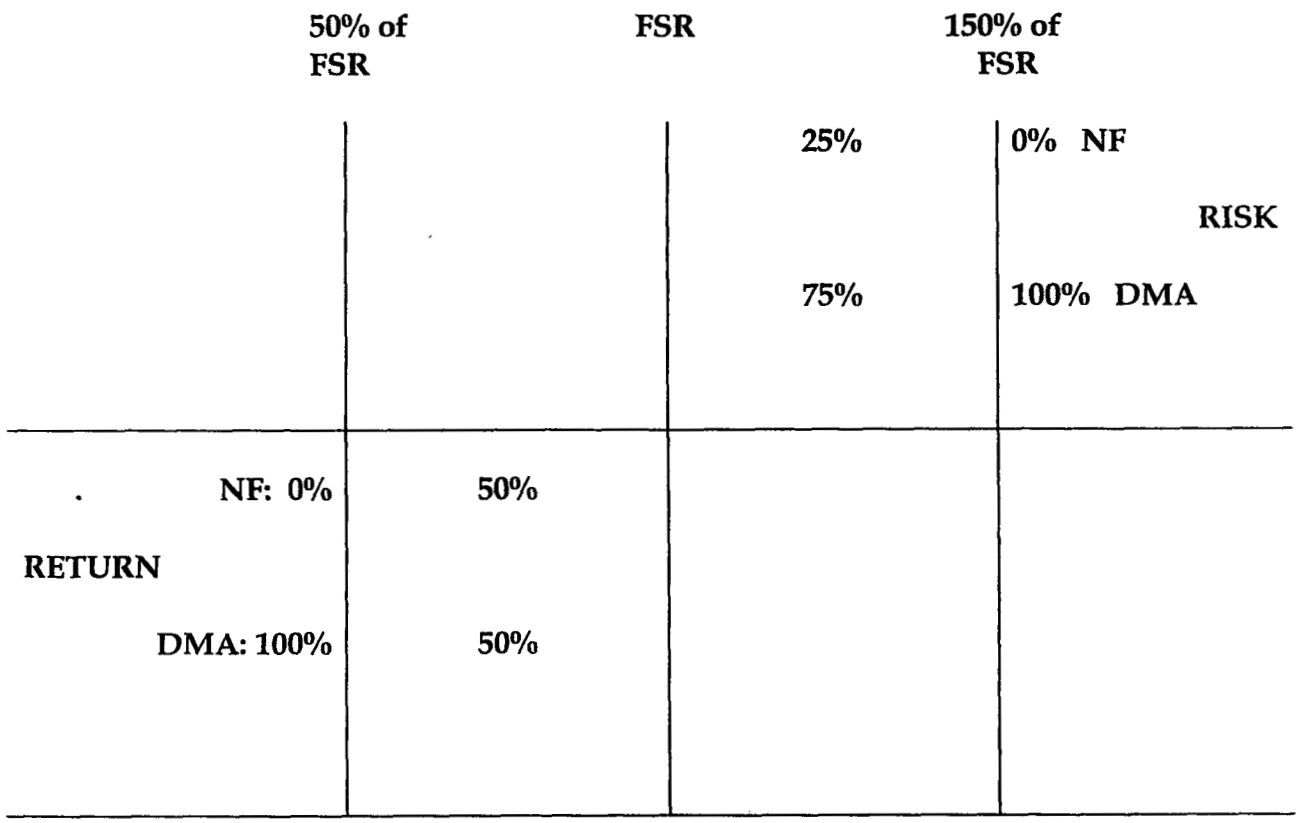
ATTACHMENT B2

OUTLIER PAYMENT MODEL



SETTLEMENT RISK SHARES

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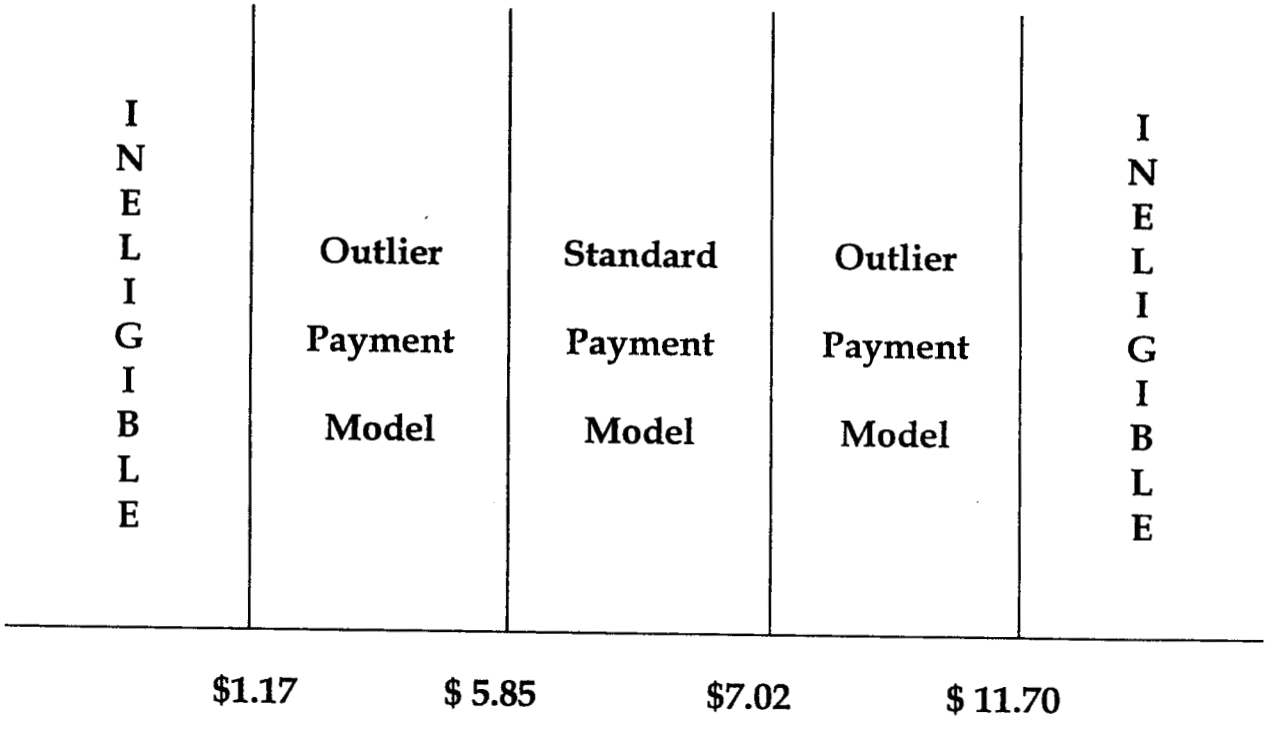
ATTACHMENT C.

FACILITY'S PILOT PARTICIPATION STATUS



HISTORICAL ANCILLARY COSTS

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ATTACHMENT D

APPLICATION FOR PARTICIPATION

PARTICIPANT INFORMATION

FACILITY NAME	
STREET	
CITY	
STATE	
ZIPCODE	
VPN	
TOTAL # BEDS	

PILOT INFORMATION

PAYMENT GROUP	_____ STANDARD _____ OUTLIER
BASELINE AMOUNT	$

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114.2 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

Section

6.01: General Provisions

(1) Scope and Effective Date. 114.2 CMR 6.00 governs the rates of payment effective January 1, 1999 for services rendered to Publicly-Aided and Industrial Accident Residents by Nursing Facilities including residents in a Residential Care Unit of a Nursing Facility.

(2) Authority. 114.2 CMR 6.00 is adopted pursuant to M.G.L. c. 118G.

6.02: General Definitions

As used in 114.2 CMR 6.00, unless the context requires otherwise, terms have the following meanings. All defined terms in 114.2 CMR 6.00 are capitalized.

ACE Group. The Audit, Compliance and Evaluation Group of the Division of Health Care Finance and Policy.

Actual Utilization Rate. The occupancy of a Nursing Facility calculated by dividing total Patient Days by Maximum Available Bed Days.

Additions. New Units or enlargements of existing Units which may or may not be accompanied by an increase in Licensed Bed Capacity.

Administrative and General Costs. Administrative and General Costs include the amounts reported in the following accounts: administrator salaries; payroll taxes - administrator; worker's compensation - administrator; group life/health - administrator; administrator pensions; other administrator benefits; clerical,; EDP/payroll/bookkeeping services; administrator-in-training; office supplies; phone; conventions and meetings; help wanted advertisement; licenses and dues, resident-care related; education and training - administration; accounting - other; insurance - malpractice; other operating expenses; realty company variable costs; management company allocated variable costs; and management company allocated fixed costs. For facilities organized as sole proprietors or partnerships and for which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits, administrative and general costs shall include an imputed value of $69,781 to reflect the costs of such services.

Administrator-in-Training. A person registered with the Board of Registration of Nursing Home Administrators and involved in a course of training as described in 245 CMR.

Audit. An examination of the Provider's cost report and supporting documentation to evaluate the accuracy of the financial statements and identification of Medicaid patient-related costs.

Building. Building Costs include the direct cost of construction of the structure that houses residents and expenditures for service Equipment and fixtures such as elevators, plumbing and electrical fixtures that are made a

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permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use, such as permits, engineering and architect's fees and certain legal fees. Building Costs include interest paid during construction to Building Costs but not Mortgage Acquisition Costs.

Capital Costs. Capital Costs include Building Depreciation, Long Term Interest Expense, Building Insurance, Real Estate Taxes, non-income portion of Massachusetts Corp. Excise Taxes, Other Rent and Other Fixed Costs.

Case-Mix Category. One of ten categories of resident acuity that represents a range of Management Minutes.

Change of Ownership. A bona fide transfer, for reasonable consideration, of all the powers and indicia of ownership. A Change of Ownership may not occur between Related Parties. A Change of Ownership must be a sale of assets of the Provider rather than a method of financing. A change in the legal form of the Provider does not constitute a Change of Ownership unless the other criteria are met.

Constructed Bed Capacity. A Nursing Facility's "Bed Capacity (or Clinical Bed Capacity)" as defined in the Department's regulation 105 CMR 100.020 which states: the capacity of a building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It includes rooms designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such appurtenances are actually in place, with any necessary utilities (e.g. drinking water, sprinkler lines, oxygen, electric current) with either outlets or capped lines within the room.

Department. The Massachusetts Department of Public Health.

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists provided directly to individual Residents to reduce physical or mental disability and to restore the Resident to maximum functional level. Direct Restorative Therapy Services are provided only upon written order of a physician, physician assistant or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual Resident.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Equipment. A fixed asset, usually moveable, accessory or supplemental to the Building, including such items as beds, tables, and wheelchairs .

Hospital-Based Nursing Facility. A separate Unit or Units located in the hospital building licensed for both hospital and Long-Term care services which comprise less than a majority of the facility's total licensed beds. It does not include free-standing Nursing Facilities owned by hospitals.

Improvements. Expenditures that increase the quality of the Building by rearranging the Building layout or substituting improved components for old components so that the Provider is in some way better than it was before the renovation. Improvements do not add to or expand the square footage of the Building. An improvement is measured by the Provider's increased productivity, greater capacity or longer life.

Indirect Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide orientation programs for aides and assistants, in-service training to staff, and consultation and planning for continuing care after discharge.

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Industrial Accident Resident. A person receiving Nursing Facility services for which an employer or an insurer is liable under the workers compensation act, M.G.L. c. 152, et seq.

Land. Land Costs include the purchase price plus the cost of bringing land to a productive use including, but not limited to, commissions to agents, attorneys' fees, demolition of Buildings, clearing and grading the land, constructing access roads, off-site sewer and water lines, and public utility charges necessary to service the land; and land Improvements completed before the purchase. The land must be necessary for the care of Publicly-Aided Residents.

Licensed Bed Capacity. The number of beds for which the Nursing Facility is either licensed by the Department of Public Health pursuant to 105 CMR 100.020, or for a Nursing Facility operated by a government agency, the number of beds approved by the Department. The Department issues a license for a particular level of care.

Major Addition. A newly constructed addition to a Nursing Facility which increases the Licensed Bed Capacity of the facility by 50% or more.

Management Minutes. A method of measuring resident care intensity, or case mix, by discrete care-giving activities or the characteristics of residents found to require a given amount of care.

Management Minutes Questionnaire. A form used to collect resident care information including but not limited to case-mix information as defined by the Division of Medical Assistance.

Massachusetts Corporate Excise Tax. Those taxes which have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

Maximum Available Bed Days. The total number of licensed beds for the calendar year, determined by multiplying the Mean Licensed Bed Capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A Provider's weighted average Licensed Bed Capacity for the calendar year, determined by (1) multiplying Maximum Available Bed Days for each level of care by the number of days in the calendar year for which the Nursing Facility was licensed for each level and (2) adding the Maximum Available Bed Days for each level and (3) dividing the total Maximum Available Bed Days by the number of days in the calendar year.

Mortgage Acquisition Costs. Those costs (such as finder's fees, certain legal fees, and filing fees) that are necessary to obtain Long-Term financing through a mortgage, bond or other Long-Term debt instrument.

New Facility. A Nursing Facility that opens on or after February 1, 1998. A Replacement Facility is not a New Facility.

Non-Profit Provider. A Provider either organized for charitable purposes or recognized as a non-profit entity by the Internal Revenue Service. It includes Massachusetts corporations organized under M.G.L. c.180; tax exempt clubs, associations, organizations, or entities; corporations organized under M.G.L. c.156B and granted a 501(c)(3) tax exemption; and facilities owned or operated by governmental Units.

Nursing Costs. Nursing costs include the 1996 Reported Costs for Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, Workers Compensation, Payroll Tax, and Fringe Benefits, including Pension Expense.

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Nursing Facility. A nursing or convalescent home; an infirmary maintained in a town; a charitable home for the aged, as defined in M.G.L. c. 111, s.71; or a Nursing Facility operating under a hospital license issued by the Department pursuant to M.G.L. c. 111, and certified by the Department for participation in the State Medical Assistance Program. It includes facilities that operate a licensed residential care Unit within the Nursing Facility.

Other Operating Costs. Other Operating Costs include, but are not limited to the following reported costs: plant, operations and maintenance; dietary; laundry; housekeeping; ward clerks and medical records librarian; medical Director; Advisory Physician; Utilization Review Committee; Employee Physical Exams; Other Physician Services; House Medical Supplies Not Resold; Pharmacy Consultant; Social Service Worker; Indirect Restorative and Recreation Therapy Expense; Other Required Education; Job Related Education; Quality Assurance Professionals; Management Minute Questionnaire Nurses; Staff Development Coordinator; Motor Vehicle Expenses including, but not limited to depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax; and Administrative and General Costs.

Patient Days. The total number of days of occupancy by residents in the facility. The day of admission is included in the computation of Patient Days; the day of discharge is not included. If admission and discharge occur on the same day, one resident day is included in the computation. It includes days for which a Provider reserves a vacant bed for a Publicly-Aided Resident temporarily placed in a different care situation, pursuant to an agreement between the Provider and the Division of Medical Assistance. It also includes days for which a bed is held vacant and reserved for a non-publicly-aided resident.

Private Nursing Facility. A Nursing Facility that does not have a provider agreement with the Division of Medical Assistance to provide services to publicly-assisted Residents.

Proprietary Provider. A Provider that does not meet the criteria specified in the definition of "Non-Profit Provider."

Provider. A Nursing Facility providing care to Publicly-Aided Residents or Industrial Accident Residents.

Publicly-Aided Resident. A person for whom care in a Nursing Facility is in whole or in part subsidized by the Commonwealth or a political sub-Division of the Commonwealth. Publicly-Aided Residents do not include residents whose care is in whole or in part subsidized by Medicare.

Rate Year. The calendar year in which the standard payment rates are in effect.

Related Party. An individual or organization associated or affiliated with, or which has control of, or is controlled by, the Provider; or is related to the Provider, or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended provided, however, that 10% is the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mother-in-law, brothers-in-law and sisters-in-law.

Replacement Facility. A Nursing Facility which existed prior to February 1, 1998 that replaces all of its beds and/or its entire building pursuant to an approved Determination of Need under 105 CMR 100.505(a)(6).

Reported Costs. All costs reported in the cost report, less costs adjusted and/or self-disallowed in Schedules 13 and 14 of the 1996 cost reports.

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114. 2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

Required Education. Educational activities, conducted by a recognized school or authorized organization, required to maintain a professional license of employees that provide care to Publicly-Aided Residents. Required education also includes training for nurses' aides.

Residential Care. The minimum basic care and services and protective supervision required by the Department in accordance with 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Residential Care Unit. A Unit within a Nursing Facility which has been licensed by the Department to provide residential care.

Unit. A Unit is an identifiable section of a Nursing Facility such as a wing, floor or ward as defined by the Department in 105 CMR 150.000 (Licensing of Long-Term Care Facilities).

6.03: Standard Payments.

(1) Standard Payment Rates.

(a) There are standard payment rates for Nursing and Other Operating Costs:

Case Mix Category	Nursing	Other Operating
1	16.22	51.76
2	16.22	51.76
3	16.22	51.76
4	54.76	51.76
5	54.76	51.76
6	54.76	51.76
7	54.76	51.76
8	79.27	51.76
9	79.27	51.76
10	96.47	51.76

(b) Payment rates for New Facilities and Hospital-based Nursing Facilities will be set at the Standard Payment Rates.

(c) Payment rates for all other Nursing Facilities will be set at the Standard Payment Rates effective in Rate Year 2001. For Rate Years 1999 and 2000, payment rates for such facilities will set at Transition Rates pursuant to the provisions of 114.2 CMR 6.04(4).

(2) Capital Payment.

(a) The payment for Capital Costs will be $17.29 per day for the following facilities:

1. Hospital-Based Nursing Facilities;
2. Private Nursing Facilities which sign a Provider Agreement with the Division of Medical Assistance during the Rate Year; and
3. Facilities and licensed beds that become operational on or after February 1, 1998 and which are:

a. New Facilities constructed pursuant to a Determination of Need approved after March 7, 1996;

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b. Replacement facilities which are renovated or replaced pursuant to a Determination of Need approved after March 7, 1996,
c. New Facilities constructed in Urban Underbedded areas which are exempt from the Determination of Need process;
d. New beds licensed pursuant to a Determination of Need approved after March 7, 1996; and
e. New beds in twelve-bed expansion projects which are not associated with an approved Determination of Need project.

(b) For all other facilities, the payment for Capital Costs will be determined pursuant to 114.2 CMR 6.04(3).

(3) Ancillary Costs. Unless a Provider participates in the Ancillary Pilot Program with the Division of Medical Assistance, or a Provider's rates include Ancillary Services pursuant to the regulations or written policy of the purchasing agency, the Provider must bill Ancillary Services directly to the purchaser in accordance with the purchaser's regulations or policies.

(4) Residential Care Beds. The Division will establish separate Nursing and Other Operating Costs payment rates for Residential Care Beds in a dually-licensed facility. The Division will determine the proportion of 1996 reported costs allocable to the rest home beds. It will exclude from the calculation reported costs for Ward Clerk, Utilization Review, Medical Records, and Advisory Physician. Allowable costs will be limited to the 1999 freestanding rest home ceiling established in 114.2 CMR 4.00. The facility's rate for Residential Care Beds will not exceed its 1999 Payment Rate for Case Mix Category 1 Nursing Facility Residents, and the rate will not be lower than its certified 1998 rate for Residential Care Beds. The Residential Care Bed rate is not subject to the Total Payment Adjustment set forth in 114.2 CMR 6.04(6).

(5) Special Provisions

(a) Reopened Beds Out of Service. Facilities with licensed beds that were out of service prior to 1997 which re-open in 1999 will receive the lower of the Standard Payment Rates or the most recent prior billing rates inflated to 1997 for Nursing and Other Operating Costs.

(b) Pediatric Nursing Homes. Payments to facilities licensed to provide pediatric nursing facility services will be determined using 1996 Reported Costs for Nursing and Other Operating Costs, excluding Administration and General Costs. Administration and General Costs will be based on 1996 costs subject to a cap of $10.51. A pediatric nursing facility may apply to the Division for a rate adjustment for the otherwise unrecognized medical costs of residents over the age of 22 who were previously enrolled in the facility's Chapter 766 program. The Division will calculate an adjustment to include the reasonable costs for these services subject to approval by the Division of Medical Assistance.

(c) Rates for Innovative and Special Programs. The Division will include an allowance for costs and expenses to establish and maintain an innovative program for providing care to Publicly-Aided Residents if:

1. The Provider has received prior written approval from the Executive Office of Elder Affairs to establish and maintain a program; or
2. The Provider participates in a special program pursuant to a contract with the Division of Medical Assistance under which it has agreed to accept residents designated by that agency.

6.04: Transition Payment Rates. The Transition Payment Rates are the sum of the Payments for Nursing, Other Operating Costs, and Capital, subject to the Total Payment Adjustment.

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114. 2 CMR 6.00 STANDARD PAYMENTS TO NURSING FACILITIES

(1) Nursing Transition Rates.

(a) Determination of Facility Rates. For each facility, the Division will calculate ten case mix adjusted nursing rates.

1. Allowable Nursing Cost per Management Minute. The Division will determine a facility's Allowable Nursing Costs as follows:

a. 1996 Actual Nursing Cost per Management Minute. A facility's Actual Nursing Cost per Management Minute is the sum of its reported Nursing Costs divided by the greater of (1) 96% of the current Licensed Bed Capacity for 1996 times 366 or (2) actual 1996 patient days, divided by the facility's 1996 average Management Minutes.

b. Determination of Nursing Ceiling. The Division will calculate a Nursing Ceiling based upon reported 1996 average nursing cost per management minute as follows:

i. The Division will calculate a nursing per diem for each facility by dividing the facility's claimed 1996 nursing costs by the greater of 1996 patient days or 96% of the Mean Licensed Bed Capacity in 1996 times 366.

ii. The Division will calculate the 1996 average nursing cost per Management Minute for each facility by dividing the 1996 nursing cost per diem by the facility's 1996 average Management Minutes.

iii. The Nursing Ceiling is 110% of the median claimed 1996 average Nursing Cost per Management Minute, or $.325 per Management Minute.

c. Allowable Nursing Cost per Management Minute. A facility's Allowable Nursing Cost per Management Minute is the lower of its 1996 Actual Nursing Cost per Management Minute or the Nursing Ceiling.

2. Calculation of Ten Nursing Per diem Rates. The Division will multiply the allowable nursing cost per management minute by the facility's average management minutes per case-mix category to obtain a per diem rate for each category. If the facility-specific mean minutes per case mix category equals zero, the Division will use the industry median minutes for that category.

3. Calculation of Weighted Nursing Per Diems for Four Nursing Payment Groups.

a. The Division will calculate weighted nursing per diems based on the four payment categories below:

Payment Group	Casemix Category
A	1 - 3
B	4 - 7
C	8 - 9
D	10

b. It will calculate the proportion of residents in each of the four payment groups by summing the casemix proportions for the categories in each of the four payment groups.

c. It will calculate casemix weights within each payment group by dividing:

i. the casemix proportion for the casemix category, by

ii. the proportion of residents in its payment group from 114.2 CMR 6.04(1)(a)3a.

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d. For each casemix category, it will multiply the nursing per diem from 114.2 CMR 6.04(1)(a)3b by the casemix weight from 114.2 CMR 6.04(1)(a)3c.
e. For each payment group, it will sum the casemix-weighted nursing per diems from 114.2 CMR 6.04(1)(a)3d to obtain four weighted nursing per diems.
f. The Division will calculate the Facility Rates by multiplying the four weighted nursing per diems by 7.68%.

(b) Nursing Transition Payments.

1. For Rate Year 1999, the Nursing Payments are the sum of (a) 66.7% of the Facility Rates and (b) 33.3% of the Standard Payments for Nursing.
2. For Rate Year 2000, the Nursing Payments are the sum of (a) 33.3% of the Facility Rates and (b) 66.7% of the Standard Payments for Nursing.
3. For Rate Year 2001, all facilities will receive the Standard Payments for Nursing.

(2) Other Operating Cost Transition Payment.

(a) Determination of the Allowable Other Operating Costs. The Division will determine the facility's Allowable Other Operating Costs per diem as follows:

1. The Division will subtract the facility's reported 1996 Administrative and General expenses from reported 1996 Other Operating expenses to obtain Net Other Operating Expenses.
2. The facility's Net Other Operating Expenses per day is equal to Net Other Operating Expenses divided by the greater of
    a. 96% of the mean Licensed Bed Capacity in 1996 times 366, or
    b. actual patient days.
3. The facility's Allowable Administrative and General per diem is equal to the lower of
    a. reported 1996 Administrative and General expenses divided by the greater of
        i. 96% of the mean Licensed Bed Capacity in 1996 times 366, or
        ii. actual patient days, or
    b. the Administrative and General ceiling of $10.51 per day.
4. The sum of the facility's Net Other Operating Expenses per day and its Allowable Administrative and General per diem equals the facility's preliminary Other Operating Cost per diem.
5. The Division will calculate an Other Operating Cost Ceiling as follows:
    a. The Division will calculate the 1996 Other Operating Cost per diems for all facilities.
    b. The Other Operating Ceiling equals the industry median plus 6%, or $50.21.
6. A facility's Allowable Other Operating Cost is the lower of its preliminary Other Operating Cost per diem or the ceiling.
7. If a facility had reported Medicare days in 1996, the Division will reduce the facility's Allowable Other Operating Cost per diem by 1.8%.
8. The Division will multiply Allowable Other Operating Costs by 7.68%.

(b) Other Operating Cost Transition Payment.

1. For Rate Year 1999, the payment for Other Operating Costs is the sum of (a) 66.7% of the facility's Allowable Other Operating Costs and (b) 33.3% of the Other Operating Standard Payment.
2. For Rate Year 2000, the Other Operating Cost Payment will be the sum of (a) 33.3% of the facility's Allowable Other Operating Costs, adjusted for inflation, and (b) 66.7& of the Other Operating Standard Payment.

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